

Pt. 162

**PART 162—ADMINISTRATIVE
REQUIREMENTS**

Subpart A—General Provisions

- Sec.
162.100 Applicability.
162.103 Definitions.

Subparts B–C [Reserved]

**Subpart D—Standard Unique Health
Identifier for Health Care Providers**

- 162.402 Definitions.
162.404 Compliance dates of the implemen-
tation of the standard unique health
identifier for health care providers.
162.406 Standard unique health identifier for
health care providers.
162.408 National Provider System.
162.410 Implementation specifications:
Health care providers.
162.412 Implementation specifications:
Health plans.
162.414 Implementation specifications:
Health care clearinghouses.

Subpart E [Reserved]

**Subpart F—Standard Unique Employer
Identifier**

- 162.600 Compliance dates of the implemen-
tation of the standard unique employer
identifier.
162.605 Standard unique employer identifier.
162.610 Implementation specifications for
covered entities.

Subparts G–H [Reserved]

**Subpart I—General Provisions for
Transactions**

- 162.900 Compliance dates for transaction
standards and code sets.
162.910 Maintenance of standards and adop-
tion of modifications and new standards.
162.915 Trading partner agreements.
162.920 Availability of implementation spec-
ifications.
162.923 Requirements for covered entities.
162.925 Additional requirements for health
plans.
162.930 Additional rules for health care
clearinghouses.
162.940 Exceptions from standards to permit
testing of proposed modifications.

Subpart J—Code Sets

- 162.1000 General requirements.
162.1002 Medical data code sets.
162.1011 Valid code sets.

45 CFR Subtitle A (10–1–08 Edition)

**Subpart K—Health Care Claims or
Equivalent Encounter Information**

- 162.1101 Health care claims or equivalent
encounter information transaction.
162.1102 Standards for health care claims or
equivalent encounter information trans-
action.

Subpart L—Eligibility for a Health Plan

- 162.1201 Eligibility for a health plan trans-
action.
162.1202 Standards for eligibility for a
health plan transaction.

**Subpart M—Referral Certification and
Authorization**

- 162.1301 Referral certification and author-
ization transaction.
162.1302 Standard for referral certification
and authorization transaction.

Subpart N—Health Care Claim Status

- 162.1401 Health care claim status trans-
action.
162.1402 Standards for health care claim sta-
tus transaction.

**Subpart O—Enrollment and Disenrollment
in a Health Plan**

- 162.1501 Enrollment and disenrollment in a
health plan transaction.
162.1502 Standards for enrollment and
disenrollment in a health plan trans-
action.

**Subpart P—Health Care Payment and
Remittance Advice**

- 162.1601 Health care payment and remit-
tance advice transaction.
162.1602 Standards for health care payment
and remittance advice transaction.

**Subpart Q—Health Plan Premium
Payments**

- 162.1701 Health plan premium payments
transaction.
162.1702 Standards for health plan premium
payments transaction.

Subpart R—Coordination of Benefits

- 162.1801 Coordination of benefits trans-
action.
162.1802 Standards for coordination of bene-
fits information transaction.

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Stat. 2021–2031, and sec. 264 of Pub. L. 104–191,
110 Stat. 2033–2034 (42 U.S.C. 1320d–2 (note)).

Department of Health and Human Services

§ 162.404

SOURCE: 65 FR 50367, Aug. 17, 2000, unless otherwise noted.

Subpart A—General Provisions

§ 162.100 Applicability.

Covered entities (as defined in § 160.103 of this subchapter) must comply with the applicable requirements of this part.

§ 162.103 Definitions.

For purposes of this part, the following definitions apply:

Code set means any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. A code set includes the codes and the descriptors of the codes.

Code set maintaining organization means an organization that creates and maintains the code sets adopted by the Secretary for use in the transactions for which standards are adopted in this part.

Data condition means the rule that describes the circumstances under which a covered entity must use a particular data element or segment.

Data content means all the data elements and code sets inherent to a transaction, and not related to the format of the transaction. Data elements that are related to the format are not data content.

Data element means the smallest named unit of information in a transaction.

Data set means a semantically meaningful unit of information exchanged between two parties to a transaction.

Descriptor means the text defining a code.

Designated standard maintenance organization (DSMO) means an organization designated by the Secretary under § 162.910(a).

Direct data entry means the direct entry of data (for example, using dumb terminals or web browsers) that is immediately transmitted into a health plan's computer.

Format refers to those data elements that provide or control the enveloping or hierarchical structure, or assist in identifying data content of, a transaction.

HCPCS stands for the Health [Care Financing Administration] Common Procedure Coding System.

Maintain or *maintenance* refers to activities necessary to support the use of a standard adopted by the Secretary, including technical corrections to an implementation specification, and enhancements or expansion of a code set. This term excludes the activities related to the adoption of a new standard or implementation specification, or modification to an adopted standard or implementation specification.

Maximum defined data set means all of the required data elements for a particular standard based on a specific implementation specification.

Segment means a group of related data elements in a transaction.

Standard transaction means a transaction that complies with the applicable standard adopted under this part.

[65 FR 50367, Aug. 17, 2000, as amended at 68 FR 8374, Feb. 20, 2003]

Subparts B–C [Reserved]

Subpart D—Standard Unique Health Identifier for Health Care Providers

SOURCE: 69 FR 3468, Jan. 23, 2004, unless otherwise noted.

§ 162.402 Definitions.

Covered health care provider means a health care provider that meets the definition at paragraph (3) of the definition of “covered entity” at § 160.103 of this subchapter.

§ 162.404 Compliance dates of the implementation of the standard unique health identifier for health care providers.

(a) *Health care providers.* A covered health care provider must comply with the implementation specifications in § 162.410 no later than May 23, 2007.

(b) *Health plans.* A health plan must comply with the implementation specifications in § 162.412 no later than one of the following dates:

(1) A health plan that is not a small health plan—May 23, 2007.

(2) A small health plan—May 23, 2008.

§ 162.406

(c) *Health care clearinghouses.* A health care clearinghouse must comply with the implementation specifications in § 162.414 no later than May 23, 2007.

§ 162.406 Standard unique health identifier for health care providers.

(a) *Standard.* The standard unique health identifier for health care providers is the National Provider Identifier (NPI). The NPI is a 10-position numeric identifier, with a check digit in the 10th position, and no intelligence about the health care provider in the number.

(b) *Required and permitted uses for the NPI.* (1) The NPI must be used as stated in § 162.410, § 162.412, and § 162.414.

(2) The NPI may be used for any other lawful purpose.

§ 162.408 National Provider System.

National Provider System. The National Provider System (NPS) shall do the following:

(a) Assign a single, unique NPI to a health care provider, provided that—

(1) The NPS may assign an NPI to a subpart of a health care provider in accordance with paragraph (g); and

(2) The Secretary has sufficient information to permit the assignment to be made.

(b) Collect and maintain information about each health care provider that has been assigned an NPI and perform tasks necessary to update that information.

(c) If appropriate, deactivate an NPI upon receipt of appropriate information concerning the dissolution of the health care provider that is an organization, the death of the health care provider who is an individual, or other circumstances justifying deactivation.

(d) If appropriate, reactivate a deactivated NPI upon receipt of appropriate information.

(e) Not assign a deactivated NPI to any other health care provider.

(f) Disseminate NPS information upon approved requests.

(g) Assign an NPI to a subpart of a health care provider on request if the identifying data for the subpart are unique.

45 CFR Subtitle A (10–1–08 Edition)

§ 162.410 Implementation specifications: Health care providers.

(a) A covered entity that is a covered health care provider must:

(1) Obtain, by application if necessary, an NPI from the National Provider System (NPS) for itself or for any subpart of the covered entity that would be a covered health care provider if it were a separate legal entity. A covered entity may obtain an NPI for any other subpart that qualifies for the assignment of an NPI.

(2) Use the NPI it obtained from the NPS to identify itself on all standard transactions that it conducts where its health care provider identifier is required.

(3) Disclose its NPI, when requested, to any entity that needs the NPI to identify that covered health care provider in a standard transaction.

(4) Communicate to the NPS any changes in its required data elements in the NPS within 30 days of the change.

(5) If it uses one or more business associates to conduct standard transactions on its behalf, require its business associate(s) to use its NPI and other NPIs appropriately as required by the transactions that the business associate(s) conducts on its behalf.

(6) If it has been assigned NPIs for one or more subparts, comply with the requirements of paragraphs (a)(2) through (a)(5) of this section with respect to each of those NPIs.

(b) A health care provider that is not a covered entity may obtain, by application if necessary, an NPI from the NPS.

§ 162.412 Implementation specifications: Health plans.

(a) A health plan must use the NPI of any health care provider (or subpart(s), if applicable) that has been assigned an NPI to identify that health care provider on all standard transactions where that health care provider's identifier is required.

(b) A health plan may not require a health care provider that has been assigned an NPI to obtain an additional NPI.

§ 162.414 Implementation specifications: Health care clearinghouses.

A health care clearinghouse must use the NPI of any health care provider (or subpart(s), if applicable) that has been assigned an NPI to identify that health care provider on all standard transactions where that health care provider's identifier is required.

Subpart E [Reserved]

Subpart F—Standard Unique Employer Identifier

SOURCE: 67 FR 38020, May 31, 2002, unless otherwise noted.

§ 162.600 Compliance dates of the implementation of the standard unique employer identifier.

(a) *Health care providers.* Health care providers must comply with the requirements of this subpart no later than July 30, 2004.

(b) *Health plans.* A health plan must comply with the requirements of this subpart no later than one of the following dates:

(1) *Health plans other than small health plans*—July 30, 2004.

(2) *Small health plans*—August 1, 2005.

(c) *Health care clearinghouses.* Health care clearinghouses must comply with the requirements of this subpart no later than July 30, 2004.

§ 162.605 Standard unique employer identifier.

The Secretary adopts the EIN as the standard unique employer identifier provided for by 42 U.S.C. 1320d-2(b).

§ 162.610 Implementation specifications for covered entities.

(a) The standard unique employer identifier of an employer of a particular employee is the EIN that appears on that employee's IRS Form W-2, Wage and Tax Statement, from the employer.

(b) A covered entity must use the standard unique employer identifier (EIN) of the appropriate employer in standard transactions that require an employer identifier to identify a person or entity as an employer, including where situationally required.

(c) Required and permitted uses for the Employer Identifier.

(1) The Employer Identifier must be used as stated in § 162.610(b).

(2) The Employer Identifier may be used for any other lawful purpose.

[67 FR 38020, May 31, 2002, as amended at 69 FR 3469, Jan. 23, 2004]

Subparts G–H [Reserved]

Subpart I—General Provisions for Transactions

§ 162.900 Compliance dates for transaction standards and code sets.

(a) *Small health plans.* All small health plans must comply with applicable requirements of subparts I through R of this part no later than October 16, 2003.

(b) *Covered entities that timely submitted a compliance plan.* Any covered entity, other than a small health plan, that timely submitted a compliance plan with the Secretary under the provisions of section 2 of Pub. L. 107-105, 115 Stat. 1003 (ASCA) must comply with the applicable requirements of subparts I through R of this part no later than October 16, 2003.

(c) *Covered entities that did not timely submit a compliance plan.* Any covered entity, other than a small health plan, that did not timely submit a compliance plan under the provisions of section 2 of Pub. L. 107-105, 115 Stat. 1003 (ASCA) must comply with the applicable requirements of subparts I through R of this part—

(1) Beginning on October 16, 2002, and ending on October 15, 2003—

(i) For the corresponding time period; or

(ii) For the time period beginning on October 16, 2003.

(2) Beginning on and after October 16, 2003, for the corresponding time period.

[68 FR 8396, Feb. 20, 2003]

§ 162.910 Maintenance of standards and adoption of modifications and new standards.

(a) *Designation of DSMOs.* (1) The Secretary may designate as a DSMO an organization that agrees to conduct, to the satisfaction of the Secretary, the following functions:

§ 162.915

(i) Maintain standards adopted under this subchapter.

(ii) Receive and process requests for adopting a new standard or modifying an adopted standard.

(2) The Secretary designates a DSMO by notice in the FEDERAL REGISTER.

(b) *Maintenance of standards.* Maintenance of a standard by the appropriate DSMO constitutes maintenance of the standard for purposes of this part, if done in accordance with the processes the Secretary may require.

(c) *Process for modification of existing standards and adoption of new standards.* The Secretary considers a recommendation for a proposed modification to an existing standard, or a proposed new standard, only if the recommendation is developed through a process that provides for the following:

(1) Open public access.

(2) Coordination with other DSMOs.

(3) An appeals process for each of the following, if dissatisfied with the decision on the request:

(i) The requestor of the proposed modification.

(ii) A DSMO that participated in the review and analysis of the request for the proposed modification, or the proposed new standard.

(4) Expedited process to address content needs identified within the industry, if appropriate.

(5) Submission of the recommendation to the National Committee on Vital and Health Statistics (NCVHS).

§ 162.915 Trading partner agreements.

A covered entity must not enter into a trading partner agreement that would do any of the following:

(a) Change the definition, data condition, or use of a data element or segment in a standard.

(b) Add any data elements or segments to the maximum defined data set.

(c) Use any code or data elements that are either marked “not used” in the standard’s implementation specification or are not in the standard’s implementation specification(s).

(d) Change the meaning or intent of the standard’s implementation specification(s).

45 CFR Subtitle A (10–1–08 Edition)

§ 162.920 Availability of implementation specifications.

A person or an organization may directly request copies of the implementation standards described in subparts I through R of this part from the publishers listed in this section. The Director of the Office of the Federal Register approves the implementation specifications described in this section for incorporation by reference in subparts I through R of this part in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. The implementation specifications described in this paragraph are also available for inspection by the public at the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244 or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copy requests must be accompanied by the name of the standard, number, if applicable, and version number. Implementation specifications are available for the following transactions:

(a) *ASC X12N specifications.* The implementation specifications for ASC X12N standards may be obtained from the Washington Publishing Company, PMB 161, 5284 Randolph Road, Rockville, MD, 20852–2116; Telephone (301) 949–9740; and FAX: (301) 949–9742. They are also available through the Washington Publishing Company on the Internet at <http://www.wpc-edi.com/>. The transaction implementation specifications are as follows:

(1) The ASC X12N 837—Health Care Claim: Dental, Version 4010, May 2000, Washington Publishing Company, 004010X097 and Addenda to Health Care Claim: Dental, Version 4010, October 2002, Washington Publishing Company, 004010X097A1, as referenced in § 162.1102 and § 162.1802.

(2) The ASC X12N 837—Health Care Claim: Professional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X098 and Addenda to Health Care Claim: Professional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing

Company, 004010X098A1, as referenced in § 162.1102 and § 162.1802.

(3) The ASC X12N 837—Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X096 and Addenda to Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X096A1 as referenced in § 162.1102 and § 162.1802.

(4) The ASC X12N 835—Health Care Claim Payment/Advice, Version 4010, May 2000, Washington Publishing Company, 004010X091, and Addenda to Health Care Claim Payment/Advice, Version 4010, October 2002, Washington Publishing Company, 004010X091A1 as referenced in § 162.1602.

(5) ASC X12N 834—Benefit Enrollment and Maintenance, Version 4010, May 2000, Washington Publishing Company, 004010X095 and Addenda to Benefit Enrollment and Maintenance, Version 4010, October 2002, Washington Publishing Company, 004010X095A1, as referenced in § 162.1502.

(6) The ASC X12N 820—Payroll Deducted and Other Group Premium Payment for Insurance Products, Version 4010, May 2000, Washington Publishing Company, 004010X061, and Addenda to Payroll Deducted and Other Group Premium Payment for Insurance Products, Version 4010, October 2002, Washington Publishing Company, 004010X061A1, as referenced in § 162.1702.

(7) The ASC X12N 278—Health Care Services Review—Request for Review and Response, Version 4010, May 2000, Washington Publishing Company, 004010X094 and Addenda to Health Care Services Review—Request for Review and Response, Version 4010, October 2002, Washington Publishing Company, 004010X094A1, as referenced in § 162.1302.

(8) The ASC X12N-276/277 Health Care Claim Status Request and Response, Version 4010, May 2000, Washington Publishing Company, 004010X093 and Addenda to Health Care Claim Status Request and Response, Version 4010, October 2002, Washington Publishing Company, 004010X093A1, as referenced in § 162.1402.

(9) The ASC X12N 270/271—Health Care Eligibility Benefit Inquiry and Response, Version 4010, May 2000, Washington Publishing Company,

004010X092 and Addenda to Health Care Eligibility Benefit Inquiry and Response, Version 4010, October 2002, Washington Publishing Company, 004010X092A1, as referenced in § 162.1202.

(b) *Retail pharmacy specifications.* The implementation specifications for retail pharmacy standards may be obtained for a fee from the National Council for Prescription Drug Programs (NCPDP), 9240 E. Raintree Drive, Scottsdale, AZ 85260; Telephone (480) 477-1000; and FAX (480) 767-1042. They may also be obtained through the Internet at <http://www.ncdp.org>. The transaction implementation specifications are as follows:

(1) The Telecommunication Standard Implementation Guide Version 5, Release 1 (Version 5.1), September 1999, National Council for Prescription Drug Programs, as referenced in § 162.1102, § 162.1202, § 162.1302, § 162.1602, and § 162.1802.

(2) The Batch Standard Batch Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000, supporting Telecommunication Standard Implementation Guide, Version 5, Release 1 (Version 5.1) for the NCPDP Data Record in the Detail Data Record, National Council for Prescription Drug Programs, as referenced in § 162.1102, § 162.1202, § 162.1302, and § 162.1802.

(3) The National Council for Prescription Drug Programs (NCPDP) equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1, Release 0, February 1, 1996, as referenced in § 162.1102, § 162.1202, § 162.1602, and § 162.1802.

[68 FR 8396, Feb. 20, 2003, as amended at 69 FR 18803, Apr. 9, 2004]

§ 162.923 Requirements for covered entities.

(a) *General rule.* Except as otherwise provided in this part, if a covered entity conducts with another covered entity (or within the same covered entity), using electronic media, a transaction for which the Secretary has adopted a standard under this part, the covered entity must conduct the transaction as a standard transaction.

(b) *Exception for direct data entry transactions.* A health care provider electing to use direct data entry offered by a health plan to conduct a

§ 162.925

transaction for which a standard has been adopted under this part must use the applicable data content and data condition requirements of the standard when conducting the transaction. The health care provider is not required to use the format requirements of the standard.

(c) *Use of a business associate.* A covered entity may use a business associate, including a health care clearinghouse, to conduct a transaction covered by this part. If a covered entity chooses to use a business associate to conduct all or part of a transaction on behalf of the covered entity, the covered entity must require the business associate to do the following:

(1) Comply with all applicable requirements of this part.

(2) Require any agent or subcontractor to comply with all applicable requirements of this part.

§ 162.925 Additional requirements for health plans.

(a) *General rules.* (1) If an entity requests a health plan to conduct a transaction as a standard transaction, the health plan must do so.

(2) A health plan may not delay or reject a transaction, or attempt to adversely affect the other entity or the transaction, because the transaction is a standard transaction.

(3) A health plan may not reject a standard transaction on the basis that it contains data elements not needed or used by the health plan (for example, coordination of benefits information).

(4) A health plan may not offer an incentive for a health care provider to conduct a transaction covered by this part as a transaction described under the exception provided for in § 162.923(b).

(5) A health plan that operates as a health care clearinghouse, or requires an entity to use a health care clearinghouse to receive, process, or transmit a standard transaction may not charge fees or costs in excess of the fees or costs for normal telecommunications that the entity incurs when it directly transmits, or receives, a standard transaction to, or from, a health plan.

(b) *Coordination of benefits.* If a health plan receives a standard transaction and coordinates benefits with another

45 CFR Subtitle A (10–1–08 Edition)

health plan (or another payer), it must store the coordination of benefits data it needs to forward the standard transaction to the other health plan (or other payer).

(c) *Code sets.* A health plan must meet each of the following requirements:

(1) Accept and promptly process any standard transaction that contains codes that are valid, as provided in subpart J of this part.

(2) Keep code sets for the current billing period and appeals periods still open to processing under the terms of the health plan's coverage.

§ 162.930 Additional rules for health care clearinghouses.

When acting as a business associate for another covered entity, a health care clearinghouse may perform the following functions:

(a) Receive a standard transaction on behalf of the covered entity and translate it into a nonstandard transaction (for example, nonstandard format and/or nonstandard data content) for transmission to the covered entity.

(b) Receive a nonstandard transaction (for example, nonstandard format and/or nonstandard data content) from the covered entity and translate it into a standard transaction for transmission on behalf of the covered entity.

§ 162.940 Exceptions from standards to permit testing of proposed modifications.

(a) *Requests for an exception.* An organization may request an exception from the use of a standard from the Secretary to test a proposed modification to that standard. For each proposed modification, the organization must meet the following requirements:

(1) *Comparison to a current standard.* Provide a detailed explanation, no more than 10 pages in length, of how the proposed modification would be a significant improvement to the current standard in terms of the following principles:

(i) Improve the efficiency and effectiveness of the health care system by leading to cost reductions for, or improvements in benefits from, electronic health care transactions.

(ii) Meet the needs of the health data standards user community, particularly health care providers, health plans, and health care clearinghouses.

(iii) Be uniform and consistent with the other standards adopted under this part and, as appropriate, with other private and public sector health data standards.

(iv) Have low additional development and implementation costs relative to the benefits of using the standard.

(v) Be supported by an ANSI-accredited SSO or other private or public organization that would maintain the standard over time.

(vi) Have timely development, testing, implementation, and updating procedures to achieve administrative simplification benefits faster.

(vii) Be technologically independent of the computer platforms and transmission protocols used in electronic health transactions, unless they are explicitly part of the standard.

(viii) Be precise, unambiguous, and as simple as possible.

(ix) Result in minimum data collection and paperwork burdens on users.

(x) Incorporate flexibility to adapt more easily to changes in the health care infrastructure (such as new services, organizations, and provider types) and information technology.

(2) *Specifications for the proposed modification.* Provide specifications for the proposed modification, including any additional system requirements.

(3) *Testing of the proposed modification.* Provide an explanation, no more than 5 pages in length, of how the organization intends to test the standard, including the number and types of health plans and health care providers expected to be involved in the test, geographical areas, and beginning and ending dates of the test.

(4) *Trading partner concurrences.* Provide written concurrences from trading partners who would agree to participate in the test.

(b) *Basis for granting an exception.* The Secretary may grant an initial exception, for a period not to exceed 3 years, based on, but not limited to, the following criteria:

(1) An assessment of whether the proposed modification demonstrates a sig-

nificant improvement to the current standard.

(2) The extent and length of time of the exception.

(3) Consultations with DSMOs.

(c) *Secretary's decision on exception.* The Secretary makes a decision and notifies the organization requesting the exception whether the request is granted or denied.

(1) *Exception granted.* If the Secretary grants an exception, the notification includes the following information:

(i) The length of time for which the exception applies.

(ii) The trading partners and geographical areas the Secretary approves for testing.

(iii) Any other conditions for approving the exception.

(2) *Exception denied.* If the Secretary does not grant an exception, the notification explains the reasons the Secretary considers the proposed modification would not be a significant improvement to the current standard and any other rationale for the denial.

(d) *Organization's report on test results.* Within 90 days after the test is completed, an organization that receives an exception must submit a report on the results of the test, including a cost-benefit analysis, to a location specified by the Secretary by notice in the FEDERAL REGISTER.

(e) *Extension allowed.* If the report submitted in accordance with paragraph (d) of this section recommends a modification to the standard, the Secretary, on request, may grant an extension to the period granted for the exception.

Subpart J—Code Sets

§ 162.1000 General requirements.

When conducting a transaction covered by this part, a covered entity must meet the following requirements:

(a) *Medical data code sets.* Use the applicable medical data code sets described in § 162.1002 as specified in the implementation specification adopted under this part that are valid at the time the health care is furnished.

(b) *Nonmedical data code sets.* Use the nonmedical data code sets as described in the implementation specifications adopted under this part that are valid

§ 162.1002

at the time the transaction is initiated.

§ 162.1002 Medical data code sets.

The Secretary adopts the following maintaining organization's code sets as the standard medical data code sets:

(a) For the period from October 16, 2002 through October 15, 2003:

(1) *International Classification of Diseases, 9th Edition, Clinical Modification, (ICD-9-CM), Volumes 1 and 2* (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by HHS, for the following conditions:

- (i) Diseases.
- (ii) Injuries.
- (iii) Impairments.
- (iv) Other health problems and their manifestations.

(v) Causes of injury, disease, impairment, or other health problems.

(2) *International Classification of Diseases, 9th Edition, Clinical Modification, Volume 3 Procedures* (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by HHS, for the following procedures or other actions taken for diseases, injuries, and impairments on hospital inpatients reported by hospitals:

- (i) Prevention.
- (ii) Diagnosis.
- (iii) Treatment.
- (iv) Management.

(3) *National Drug Codes (NDC)*, as maintained and distributed by HHS, in collaboration with drug manufacturers, for the following:

- (i) Drugs
- (ii) Biologics.

(4) *Code on Dental Procedures and Nomenclature*, as maintained and distributed by the American Dental Association, for dental services.

(5) The combination of *Health Care Financing Administration Common Procedure Coding System (HCPCS)*, as maintained and distributed by HHS, and *Current Procedural Terminology, Fourth Edition (CPT-4)*, as maintained and distributed by the American Medical Association, for physician services and other health care services. These services include, but are not limited to, the following:

- (i) Physician services.

45 CFR Subtitle A (10-1-08 Edition)

(ii) Physical and occupational therapy services.

(iii) Radiologic procedures.

(iv) Clinical laboratory tests.

(v) Other medical diagnostic procedures.

(vi) Hearing and vision services.

(vii) Transportation services including ambulance.

(6) *The Health Care Financing Administration Common Procedure Coding System (HCPCS)*, as maintained and distributed by HHS, for all other substances, equipment, supplies, or other items used in health care services. These items include, but are not limited to, the following:

- (i) Medical supplies.
- (ii) Orthotic and prosthetic devices.
- (iii) Durable medical equipment.

(b) For the period on and after October 16, 2003:

(1) The code sets specified in paragraphs (a)(1), (a)(2), (a)(4), and (a)(5) of this section.

(2) *National Drug Codes (NDC)*, as maintained and distributed by HHS, for reporting the following by retail pharmacies:

- (i) Drugs.
- (ii) Biologics.

(3) *The Healthcare Common Procedure Coding System (HCPCS)*, as maintained and distributed by HHS, for all other substances, equipment, supplies, or other items used in health care services, with the exception of drugs and biologics. These items include, but are not limited to, the following:

- (i) Medical supplies.
- (ii) Orthotic and prosthetic devices.
- (iii) Durable medical equipment.

[65 FR 50367, Aug. 17, 2000, as amended at 68 FR 8397, Feb. 20, 2003]

§ 162.1011 Valid code sets.

Each code set is valid within the dates specified by the organization responsible for maintaining that code set.

Subpart K—Health Care Claims or Equivalent Encounter Information

§ 162.1101 Health care claims or equivalent encounter information transaction.

The health care claims or equivalent encounter information transaction is

the transmission of either of the following:

(a) A request to obtain payment, and the necessary accompanying information from a health care provider to a health plan, for health care.

(b) If there is no direct claim, because the reimbursement contract is based on a mechanism other than charges or reimbursement rates for specific services, the transaction is the transmission of encounter information for the purpose of reporting health care.

§ 162.1102 Standards for health care claims or equivalent encounter information transaction.

The Secretary adopts the following standards for the health care claims or equivalent encounter information transaction:

(a) For the period from October 16, 2002 through October 15, 2003:

(1) *Retail pharmacy drug claims.* The National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Implementation Guide, Version 5, Release 1, September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1, Release 0 February 1, 1996. (Incorporated by reference in § 162.920).

(2) *Dental health care claims.* The ASC X12N 837—Health Care Claim: Dental, Version 4010, May 2000, Washington Publishing Company, 004010X097. (Incorporated by reference in § 162.920).

(3) *Professional health care claims.* The ASC X12N 837—Health Care Claim: Professional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X098. (Incorporated by reference in § 162.920).

(4) *Institutional health care claims.* The ASC X12N 837—Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X096. (Incorporated by reference in § 162.920).

(b) For the period on and after October 16, 2003:

(1) *Retail pharmacy drugs claims.* The National Council for Prescription Drug Programs (NCPDP) Telecommunication Standards Implementation Guide, Version 5, Release 1, September 1999, and equivalent NCPDP Batch Standards Batch Implementation

Guide, Version 1, Release 1, (Version 1.1), January 2000, supporting Telecommunication Version 5.1 for the NCPDP Data Record in the Detail Data Record. (Incorporated by reference in § 162.920).

(2) *Dental, health care claims.* The ASC X12N 837—Health Care Claim: Dental, Version 4010, May 2000, Washington Publishing Company, 004010X097, and Addenda to Health Care Claim: Dental, Version 4010, October 2002, Washington Publishing Company, 004010X097A1. (Incorporated by reference in § 162.920).

(3) *Professional health care claims.* The ASC X12N 837—Health Care Claims: Professional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X098 and Addenda to Health Care Claims: Professional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X098A1. (Incorporated by reference in § 162.920).

(4) *Institutional health care claims.* The ASC X12N 837—Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X096 and Addenda to Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X096A1. (Incorporated by reference in § 162.920).

[68 FR 8397, Feb. 20, 2003; 68 FR 11445, Mar. 10, 2003]

Subpart L—Eligibility for a Health Plan

§ 162.1201 Eligibility for a health plan transaction.

The eligibility for a health plan transaction is the transmission of either of the following:

(a) An inquiry from a health care provider to a health plan, or from one health plan to another health plan, to obtain any of the following information about a benefit plan for an enrollee:

(1) Eligibility to receive health care under the health plan.

(2) Coverage of health care under the health plan.

(3) Benefits associated with the benefit plan.

(b) A response from a health plan to a health care provider's (or another

§ 162.1202

health plan's) inquiry described in paragraph (a) of this section.

§ 162.1202 Standards for eligibility for a health plan transaction.

The Secretary adopts the following standards for the eligibility for a health plan transaction:

(a) For the period from October 16, 2002 through October 15, 2003:

(1) *Retail pharmacy drugs*. The National Council for Prescription Drug Programs Telecommunications Standards Implementation Guide, Version 5, Release 1, September 1999, and equivalent NCPDP Batch Standards Batch Implementation Guide, Version 1, Release 0, February 1, 1996. (Incorporated by reference in § 162.920).

(2) *Dental, professional, and institutional health care eligibility benefit inquiry and response*. The ASC X12N 270/271—Health Care Eligibility Benefit Inquiry and Response, Version 4010, May 2000, Washington Publishing Company, 004010X092. (Incorporated by reference in § 162.920).

(b) For the period on and after October 16, 2003:

(1) *Retail pharmacy drugs*. The National Council for Prescription Drug Programs Telecommunication Standard Implementation Guide, Version 5, Release 1 (Version 5.1), September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000 supporting Telecommunications Standard Implementation Guide, Version 5, Release 1 (Version 5.1) for the NCPDP Data Record in the Detail Data Record. (Incorporated by reference in § 162.920).

(2) *Dental, professional, and institutional health care eligibility benefit inquiry and response*. The ASC X12N 270/271—Health Care Eligibility Benefit Inquiry and Response, Version 4010, May 2000, Washington Publishing Company, 004010X092 and Addenda to Health Care Eligibility Benefit Inquiry and Response, Version 4010, October 2002, Washington Publishing Company, 004010X092A1. (Incorporated by reference in § 162.920).

[68 FR 8398, Feb. 20, 2003; 68 FR 11445, Mar. 10, 2003]

45 CFR Subtitle A (10–1–08 Edition)

Subpart M—Referral Certification and Authorization

§ 162.1301 Referral certification and authorization transaction.

The referral certification and authorization transaction is any of the following transmissions:

(a) A request for the review of health care to obtain an authorization for the health care.

(b) A request to obtain authorization for referring an individual to another health care provider.

(c) A response to a request described in paragraph (a) or paragraph (b) of this section.

§ 162.1302 Standards for referral certification and authorization transaction.

The Secretary adopts the following standards for the referral certification and authorization transaction:

(a) For the period from October 16, 2002, through October 15, 2003: The ASC X12N 278—Health Care Services Review—Request for Review and Response, Version 4010, May 2000, Washington Publishing Company, 004010X094. (Incorporated by reference in § 162.920).

(b) For the period on and after October 16, 2003:

(1) *Retail pharmacy drug referral certification and authorization*. The NCPDP Telecommunication Standard Implementation Guide, Version 5, Release 1 (Version 5.1), September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000, supporting Telecommunications Standard Implementation Guide, Version 5, Release 1 (Version 5.1) for the NCPDP Data Record in the Detail Data Record. (Incorporated by reference in § 162.920).

(2) *Dental, professional, and institutional referral certification and authorization*. The ASC X12N 278—Health Care Services Review—Request for Review and Response, Version 4010, May 2000, Washington Publishing Company, 004010X094 and Addenda to Health Care Services Review—Request for Review and Response, Version 4010, October 2002, Washington Publishing Company,

Department of Health and Human Services

§ 162.1602

004010X094A1. (Incorporated by reference in § 162.920).

[68 FR 8398, Feb. 20, 2003]

Subpart N—Health Care Claim Status

§ 162.1401 Health care claim status transaction.

A health care claim status transaction is the transmission of either of the following:

(a) An inquiry to determine the status of a health care claim.

(b) A response about the status of a health care claim.

§ 162.1402 Standards for health care claim status transaction.

The Secretary adopts the following standards for the health care claim status transaction:

(a) For the period from October 16, 2002 through October 15, 2003: The ASC X12N-276/277 Health Care Claim Status Request and Response, Version 4010, May 2000, Washington Publishing Company, 004010X093. (Incorporated by reference in § 162.920).

(b) For the period on and after October 16, 2003: The ASC X12N-276/277 Health Care Claim Status Request and Response, Version 4010, May 2000, Washington Publishing Company, 004010X093 and Addenda to Health Care Claim Status Request and Response, Version 4010, October 2002, Washington Publishing Company, 004010X093A1. (Incorporated by reference in § 162.920).

[68 FR 8398, Feb. 20, 2003]

Subpart O—Enrollment and Disenrollment in a Health Plan

§ 162.1501 Enrollment and disenrollment in a health plan transaction.

The enrollment and disenrollment in a health plan transaction is the transmission of subscriber enrollment information to a health plan to establish or terminate insurance coverage.

§ 162.1502 Standards for enrollment and disenrollment in a health plan transaction.

The Secretary adopts the following standards for the enrollment and

disenrollment in a health plan transaction.

(a) For the period from October 16, 2002 through October 15, 2003: ASC X12N 834—Benefit Enrollment and Maintenance, Version 4010, May 2000, Washington Publishing Company, 004010X095. (Incorporated by reference in § 162.920).

(b) For the period on and after October 16, 2003: ASC X12N 834—Benefit Enrollment and Maintenance, Version 4010, May 2000, Washington Publishing Company, 004010X095 and Addenda to Benefit Enrollment and Maintenance, Version 4010, October 2002, Washington Publishing Company, 004010X095A1. (Incorporated by reference in § 162.920).

[68 FR 8398, Feb. 20, 2003]

Subpart P—Health Care Payment and Remittance Advice

§ 162.1601 Health care payment and remittance advice transaction.

The health care payment and remittance advice transaction is the transmission of either of the following for health care:

(a) The transmission of any of the following from a health plan to a health care provider's financial institution:

(1) Payment.

(2) Information about the transfer of funds.

(3) Payment processing information.

(b) The transmission of either of the following from a health plan to a health care provider:

(1) Explanation of benefits.

(2) Remittance advice.

§ 162.1602 Standards for health care payment and remittance advice transaction.

The Secretary adopts the following standards for the health care payment and remittance advice transaction.

(a) For the period from October 16, 2002 through October 15, 2003:

(1) *Retail pharmacy drug claims and remittance advice.* The NCPDP Telecommunication Standard Implementation Guide, Version 5 Release 1, September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1 Release 0, February 1,

§ 162.1701

1996. (Incorporated by reference in § 162.920).

(2) *Dental, professional, and institutional health care claims and remittance advice.* The ASC X12N 835—Health Care Claim Payment/Advice, Version 4010, May 2000, Washington Publishing Company, 004010X091. (Incorporated by reference in § 162.920).

(b) For the period on and after October 16, 2003: *Health care claims and remittance advice.* The ASC X12N 835—Health Care Claim Payment/Advice, Version 4010, May 2000, Washington Publishing Company, 004010X091, and Addenda to Health Care Claim Payment/Advice, Version 4010, October 2002, Washington Publishing Company, 004010X091A1. (Incorporated by reference in § 162.920).

[68 FR 8398, Feb. 20, 2003]

Subpart Q—Health Plan Premium Payments

§ 162.1701 Health plan premium payments transaction.

The health plan premium payment transaction is the transmission of any of the following from the entity that is arranging for the provision of health care or is providing health care coverage payments for an individual to a health plan:

- (a) Payment.
- (b) Information about the transfer of funds.
- (c) Detailed remittance information about individuals for whom premiums are being paid.
- (d) Payment processing information to transmit health care premium payments including any of the following:
 - (1) Payroll deductions.
 - (2) Other group premium payments.
 - (3) Associated group premium payment information.

§ 162.1702 Standards for health plan premium payments transaction.

The Secretary adopts the following standards for the health care premium payments transaction.

(a) For the period from October 16, 2002 through October 15, 2003: The ASC X12N 820—Payroll Deducted and Other Group Premium Payment for Insurance Products, Version 4010, May 2000, Washington Publishing Company, 04010X061. (Incorporated by reference in § 162.920).

45 CFR Subtitle A (10–1–08 Edition)

(b) For the period on and after October 16, 2003: The ASC X12N 820—Payroll Deducted and Other Group Premium Payment for Insurance Products, Version 4010, May 2000, Washington Publishing Company, 004010X061, and Addenda to Payroll Deducted and Other Group Premium Payment for Insurance Products, Version 4010, October 2002, Washington Publishing Company, 004010X061A1. (Incorporated by reference in § 162.920).

[68 FR 8399, Feb. 20, 2003]

Subpart R—Coordination of Benefits

§ 162.1801 Coordination of benefits transaction.

The coordination of benefits transaction is the transmission from any entity to a health plan for the purpose of determining the relative payment responsibilities of the health plan, of either of the following for health care:

- (a) Claims.
- (b) Payment information.

§ 162.1802 Standards for coordination of benefits information transaction.

The Secretary adopts the following standards for the coordination of benefits information transaction.

(a) For the period from October 16, 2002 through October 15, 2003:

(1) *Retail pharmacy drug claims.* The National Council for Prescription Drug Programs Telecommunication Standard Implementation Guide, Version 5, Release 1, September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1, Release 0, February 1, 1996. (Incorporated by reference in § 162.920).

(2) *Dental health care claims.* The ASC X12N 837—Health Care Claim: Dental, Version 4010, May 2000, Washington Publishing Company, 004010X097. (Incorporated by reference in § 162.920).

(3) *Professional health care claims.* The ASC X12N 837—Health Care Claim: Professional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X098. (Incorporated by reference in § 162.920).

(4) *Institutional health care claims.* The ASC X12N 837—Health Care Claim: Institutional, Volumes 1 and 2, Version

4010, May 2000, Washington Publishing Company, 004010X096. (Incorporated by reference in § 162.920).

(b) For the period on and after October 16, 2003:

(1) *Retail pharmacy drug claims.* The National Council for Prescription Drug Programs Telecommunication Standard Implementation Guide, Version 5, Release 1 (Version 5.1), September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000, supporting Telecommunications Standard Implementation Guide, Version 5, Release 1 (Version 5.1) for the NCPDP Data Record in the Detail Data Record. (Incorporated by reference in § 162.920).

(2) *Dental health care claims.* The ASC X12N 837—Health Care Claim: Dental, Version 4010, May 2000, Washington Publishing Company, 004010X097 and Addenda to Health Care Claim: Dental, Version 4010, October 2002, Washington Publishing Company, 004010X097A1. (Incorporated by reference in § 162.920).

(3) *Professional health care claims.* The ASC X12N 837—Health Care Claim: Professional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X098 and Addenda to Health Care Claim: Professional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X098A1. (Incorporated by reference in § 162.920).

(4) *Institutional health care claims.* The ASC X12N 837—Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X096 and Addenda to Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X096A1. (Incorporated by reference in § 162.920).

[68 FR 8399, Feb. 20, 2003]

PART 163 [RESERVED]

PART 164—SECURITY AND PRIVACY

Subpart A—General Provisions

Sec.

- 164.102 Statutory basis.
- 164.103 Definitions.
- 164.104 Applicability.
- 164.105 Organizational requirements.

- 164.106 Relationship to other parts.

Subpart B [Reserved]

Subpart C—Security Standards for the Protection of Electronic Protected Health Information

- 164.302 Applicability.
 - 164.304 Definitions.
 - 164.306 Security standards: General rules.
 - 164.308 Administrative safeguards.
 - 164.310 Physical safeguards.
 - 164.312 Technical safeguards.
 - 164.314 Organizational requirements.
 - 164.316 Policies and procedures and documentation requirements.
 - 164.318 Compliance dates for the initial implementation of the security standards.
- APPENDIX A TO SUBPART C—SECURITY STANDARDS: MATRIX

Subpart D [Reserved]

Subpart E—Privacy of Individually Identifiable Health Information

- 164.500 Applicability.
- 164.501 Definitions.
- 164.502 Uses and disclosures of protected health information: General rules.
- 164.504 Uses and disclosures: Organizational requirements.
- 164.506 Uses and disclosures to carry out treatment, payment, or health care operations.
- 164.508 Uses and disclosures for which an authorization is required.
- 164.510 Uses and disclosures requiring an opportunity for the individual to agree or to object.
- 164.512 Uses and disclosures for which an authorization or opportunity to agree or object is not required.
- 164.514 Other requirements relating to uses and disclosures of protected health information.
- 164.520 Notice of privacy practices for protected health information.
- 164.522 Rights to request privacy protection for protected health information.
- 164.524 Access of individuals to protected health information.
- 164.526 Amendment of protected health information.
- 164.528 Accounting of disclosures of protected health information.
- 164.530 Administrative requirements.
- 164.532 Transition provisions.
- 164.534 Compliance dates for initial implementation of the privacy standards.

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